

**ATTACHMENT  
D  
PART 2**

**AUTHORIZED FOR LOCAL REPRODUCTION**

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE \_\_\_\_\_

**SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)**

6/25/04

GM/OTC/Probosc Khawar  
Aleem Khan, PA

09:06

Aleem Khan, PA  
Federal Transfer Center, OKC, OK

SF

HOSPITAL OR MEDICAL FACILITY

| STATUS |
|--------|
|--------|

DEPART./SERVICE

RECORDS MAINTAINED AT

SPONSOR'S NAME

SSN/ID NO.

|                         |
|-------------------------|
| RELATIONSHIP TO SPONSOR |
|-------------------------|

**PATIENT'S IDENTIFICATION:** (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

**REGISTER NO.**

WARD NO.

Kelley Leslie  
26864-039

### CHRONOLOGICAL RECORD OF MEDICAL CARE

### Medical Record

STANDARD FORM 600 (REV. 8-97)

Prescribed by GSA/ICMR  
FIRM (41 CFR) 201-9.202-1

USP LVN

## DEPARTMENT OF JUSTICE

**BUREAU OF PRISON**

TB Clearance Yes ☒ No ☐  
 1. PPD Completed: 1.8.03  
 Date \_\_\_\_\_  
 Results: OK mm \_\_\_\_\_  
 2. CXR Completed: \_\_\_\_\_  
 Date \_\_\_\_\_  
 Results: \_\_\_\_\_  
 3. Health Authority  
 Clearance: OK  
5/11/01  
 Sign \_\_\_\_\_ Date \_\_\_\_\_  
 Note:  
 Dates listed above must be within  
 one year of this transfer.

|                                |   |                              |
|--------------------------------|---|------------------------------|
| Name<br><i>Kelly Leslie</i>    | Prisoner<br>Reg. # <i>26064-039</i>       | Number<br><i>24121-2</i>     |
| Departed From<br><i>McKean</i> | Date Departed<br><i>5-21-04</i>           |                              |
| Destination<br><i>JPS</i>      | Reason for Transfer<br><i>Non Medical</i> |                              |
| Dist. Name                     | Dist. #                                   | Date in Custody<br>_ / _ / _ |

Current 1. Chronic HN 4. \_\_\_\_\_  
Medical 2. \_\_\_\_\_ 5. \_\_\_\_\_  
Problems 3. \_\_\_\_\_ 6. \_\_\_\_\_

[illegible]

Additional Comments - Blood and Body Fluid Precautions

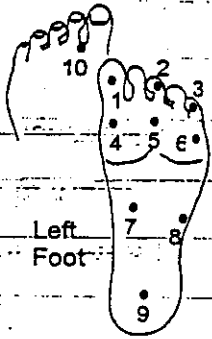
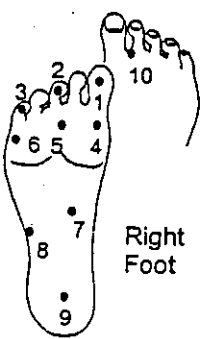
### Special Needs Affecting Transportation

|  |   |                         |
|--|---|-------------------------|
| Is prisoner medically able to travel by BUS, VAN or CAR?   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | If no, why not?         |
| Is prisoner medically able to travel by airplane?  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | If no, why not?         |
| Is prisoner medically able to stay overnight at another facility en route to destination?        | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | If no, why not?         |
| Is there any medical reason for restricting the length of time prisoner can be in travel status? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | If yes, state reason    |
| Does prisoner require any medical equipment while in transport status?                           | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | If yes, what equipment? |
| Sign and Print Name - Certifying Health Authority  | Phone Number  | Date Signed             |

## MEDICAL RECORD

## CHRONOLOGICAL RECORD

## MEDICAL CARE

| DATE   | SYMPTOMS, DIAGNOSIS, TREATMENT  |                        | TREATING ORGANIZATION (Sign each entry)     |
|--|---|------------------------|---|
| 4/13/04<br>1300  | <b>CLINIC(S):</b> ( ) Cardiac ( ) Hypertension ( ) Diabetes ( ) Infections ( ) Endocrines<br>( ) Lipid ( ) Pulmonary ( ) Mental ( ) Neurology ( ) Ortho <input checked="" type="checkbox"/> General<br>( ) Other: |                        |   |
|  | <b>SUBJECTIVE:</b> (Chief Complaint) <i>Letter Lipressor works well. Is almost H/A free. Was everyday, but now maybe 2+ a week and much decreased, with Tylenol that relieves the H/A</i>                         |                        |   |
|  | <b>Med. Compliance:</b>   |                        |   |
|  | <b>OBJECTIVE:</b> (Review System) Age: 41 Sex: <u>Male</u> Race: <u>African American</u>  |                        |   |
|  | B/P: <u>114/66</u> P: <u>68</u> Wt: <u>199</u> T: <u>96.4</u> R/R: <u>14</u> SO2%: Peak Flow:   |                        |   |
| Diabetic foot<br>Screen Test Steps<br><br><br>Left Foot   | <b>HEENT:</b> <i>PEARLA, EOMF</i>   |                        | <b>Last Op / Opth. Eval.:</b>               |
|  | <b>Heart:</b> <i>RRP</i>  |                        |   |
|  | <b>Lungs:</b> <i>Clear</i>  |                        |   |
|  | <b>Abdomen:</b> <i>soft, nondistended</i>   |                        |   |
|  | <b>Genital / Rectal:</b> <i>deferred</i>  |                        |   |
|  | <b>Extremities:</b> <i>full ROM</i>   |                        |   |
|  | <b>Neuro:</b> <i>antest</i>   |                        |   |
|  | <b>Recent Lab Results:</b> <i>none</i>  |                        |   |
| Diabetic foot<br>Screen Test Steps<br><br><br>Right Foot | <b>ASSESSMENT(S):</b> <i>Chronic H/A</i>  |                        |   |
|  | <b>DSM IV Classification</b>  |                        |   |
|  | <b>Axis I:</b>  |                        |   |
|  | <b>Axis II:</b>   |                        |   |
|  | <b>Axis III:</b>  |                        |   |
|  | <b>Preventive Care:</b>   | <b>Diet:</b> <i>sh</i> | <b>Exercise:</b> <i>sh</i>                  |
|  | <b>Tobacco Use:</b> <i>Smokes 1 a day</i>   |                        | <b>Medication Side Effects:</b> <i>none</i> |

HOSPITAL OR MEDICAL FACILITY

STATUS

DEPART. / SERVICE

RECORDS MAINTAINED

SPONSOR'S NAME

SSN / ID NO.

RELATIONSHIP TO SPONSOR

FCI McKean

 PATIENTS IDENTIFICATION: (For typed or written entries give: Name - last, first, middle;  
 ID No. or SSN; Sex; Date of Birth; Rank / Grade)

REGISTER NO.

WARD NO.

26804-039

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 6-97)

Prescribed by GSA / ICMP

Pain Level: 1 2 3 4 5 6 7 8 9 10

PLAN: *N/A*

## Patient Education:

- ( ) Discussed Test Results ☒ Discussed Tx Plan  
☒ Etiology, Complications, Prognosis, Prevention  
 ( ) Diet, Diabetic / Cardiac / Disease, Lifestyle Changes ☒ No Smoking  
☒ Medication Dosage / Administration / Compliance / Side Effects  
☒ Patient Understood Topics ☒ Instructed If Problems  
 or if running out of medication, should sign up for sick-call or send cop out.

Diagnostic Studies: ( ) CBC / Dif ( ) U / A ( ) LFT ( ) Chem. Profile ( ) Lipids ( ) HgA1c  
 ( ) PSA ( ) Viral Load ( ) CD4 ( ) Toxo Igg. ( ) Hepatitis Panel  
 ( ) CXR ( ) EKG ( ) Others:

Consultations: ( ) Optometrist ( ) Ophthalmologist ( ) Orthopedic Surgeon  
 (-) Others:

Referral for Vaccination: ( ) Influenza ( ) Pneumococcal ( ) Other:

Return to Clinic for routine Follow-Up on: *3 months*

## Treatments(s):

*Lopress 50mg i po BID dispen #60 R-3*  
*Tylenol 500mg ii Q5h PRN dispen #30 R-4*

Reviewed By:  
 V. Geza, PharmD

Eric Asp, PA-C

FCI McKean

*4/1/04*  
 H. BEAM, MD  
 FCI MCKEAN

SN 7846-88-434-4178

AUTHORIZED FOR LOCAL REPRODUCTION

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

| DATE           | SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)  |
|----------------|---|
| 3/1/04<br>0950 | <p>S: C/O H/A 3 hours a day, everyday</p> <p>Has used motrin, ASA, Omeprazole, Naproxen &amp; relief -</p> <p>States x 2-3 months this has happened. Has</p> <p>seen various members of the hospital &amp; relief -</p> <p>wants cat scan.</p> <p>No FH except HTN.</p> <p>PHYSICIAN</p> <p>neuro - intact grossly</p> <p>HEENT: PERRLA - EOM I - exam normal</p> <p>A: cluster H/A</p> <p>P: (1) Education - Flu PRN - Pt understands.</p> <p>(2) Indocin 25 mg TID dispense #20 R-1</p> <p>(3) Education - stop all meds that was previously taking -</p> <p>Pt understands.</p> <p>Reviewed By:<br/>V. Geza, PharmD</p> <p>Eric Asp, PA-C<br/>FCI McKean</p> |

|   |            |                           |                                     |
|---|------------|---------------------------|-------------------------------------|
| HOSPITAL OR MEDICAL FACILITY  | STATUS     | DEPART./SERVICE           | RECORDS MAINTAINED AT<br>FCI McKean |
| SPONSOR'S NAME  | SSN/ID NO. | RELATIONSHIP TO SPONSOR   |                                     |
| PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.) |            | REGISTER NO.<br>26864-139 | WARD NO.                            |

Kell, Leslie

CHRONOLOGICAL RECORD OF MEDICAL CARE  
Medical RecordSTANDARD FORM 600 (REV. 8-97)  
Prescribed by GSA/ICMR  
FIRM (41 CFR) 201-9.202-1

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

5/17/04  
1030

S - NAs x 3-4 mo, throbbing/aching HA  
 forehead, @ side-head → @ neck, mainly in AM  
 dur - 3-4 hrs, 8/10/10, 8/10/10, 8/10/10, 8/10/10  
 8/10/10.


O - BP 115/70 P 74 BP 199

HEENT - PERRL, EOMI

Neck - full ROM

Limp - clear

Hema - RRR, 8/10, 8/10

Neuro - no weakness, DTR 

Saturated, 8/10/10

A - ① Prob. Vascular HA - consider CAT if 8/10/10

P - ① Cont. ASA Pm

② Tylenol 500 mg q 8h Pm #30 Rx 4

③ Lopressor 50 mg BID #30 Rx 1

④ Loraz 3/17 → 3/22/04

⑤ Pt Ed - rest, red sea, kidneys discussed  
 he understands

⑥ RTC 3 mks

Reviewed By:  
V. Geza, PharmDD. Olson, MD  
Clinical Director3/24/04  
0730

Inmate Rec'd 8 pgs Medical Records

T. Petrucci, HIT

T. Petrucci, HIT

100-034-4170

AUTHORIZED FOR LOCAL REPRODUCTION

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

1-30-04 8: C/o HA last night "so bad I had to take some of  
Motrin & 4." Does not know what is causing them "I  
am stressing." @ high blood pressure medication No HA right now  
A NAD. Appears well. BP: 149/108, P: 85, Resp: 19/16  
A: n/o HTN

1-31-04 P: Dismiss Diet & exercise. Advise E/M to return in 2 wks  
for repeat B/P. p + education re: diet. Rtc in 2 wks. p.n.w.  
pt. understands. R. Glenn FNP-C

BONNIE SAYLOR, CN-P  
CERTIFIED NURSE PRACTITIONER

1-31-04 B/P ✓ 136/84 2/2/04 for  
1:00 B/P ✓ J. Glenn, FNP-C  
FCI McKean

2/2/04 9:00 Still c/o H/A, needs B/P ✓  
pain 4-5 on 1-10 scale wants CATS  
② NAD laughing. B/P 144/90 P 72  
exam - WNL neuro WNL  
③ c/o H/A  
④ 1) May use OTC Tylenol / Motrin  
2) 4/11 sick call as needed  
J. Glenn, FNP-C  
FCI McKean

|   |            |                           |                       |
|---|------------|---------------------------|-----------------------|
| HOSPITAL OR MEDICAL FACILITY  | STATUS     | DEPT./SERVICE             | RECORDS MAINTAINED AT |
| SPONSOR'S NAME  | SSN/ID NO. | RELATIONSHIP TO SPONSOR   |                       |
| PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.) |            | REGISTER NO.<br>26864-039 | WARD NO.              |

Kelley, Leslie

CHRONOLOGICAL RECORD OF MEDICAL CARE  
Medical Record

STANDARD FORM 600 (REV. 8-97)  
Prescribed by GSA/ICMR  
FIRM (41 CFR) 201-9.202-1

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

2/9/04

S: Emergency sick call

1130

was sent down for H/A that he has had for  
a month and gets 3 hours a day, everyday.  
wants to see an MD not a Pt.

O: RAP

Grossly normal

A: H/A

P: D Education - Flu &amp; sick call - Pt understands

② Flu PRN

Eric Asp Pt-C

Eric Asp, PH-C

FCI McKean

7840-00-434-4178

AUTHORIZED FOR LOCAL REPRODUCTION

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

| DATE           | SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)  |
|----------------|---|
| 1-8-09<br>0800 | <p>③ 1/2 ongoing nasal congestion &amp; cough mostly<br/>"once daily" upon arising &amp; during day<br/>twice</p> <p>1/2 nasal congestion x 3 1/2 months</p> <p>1/2 HAs x 1 year off &amp; on "right or left frontal area to<br/>all over head"</p> <p>no associated sys (vertigo, N, V, aura, medicine)</p> <p>Pain: throbbing 18/10 every day to every other day<br/>Lasting 1-2 hrs</p> <p>Use Motrin &amp; 1st help</p> |
|                | <p>③ NAS HEENT: Turbinates 3/4 bilat: = thick mucus in<br/>nasal vaults &amp; everted (blood crusts)<br/>of recent bleeding, bilat.</p> <p>T=97.6°F</p> <p>ScO<sub>2</sub> = 98%</p> <p>③ Sinus tenderness</p> <p>= unresponsive</p>  |
|                | <p>④ URE</p> <p>Dry nasal mucosa</p> <p>HA</p>  |
|                | <p>⑤ 1. Refill TPO QID per nasal sys. #20 N/A.</p> <p>2. Motrin 400mg 1-2 po TID per HA indications #40 R x 3 (three)</p> <p>3. It given instructions per to procure Saline Spray<br/>(2 sprays QID and p.r.) + CTOT (when advised you).</p> <p>4. It ref: GENTLE nose blowing only.</p> <p>5. 1st water intake</p> <p>6. It understands &amp; plan FU per Dr. VC.</p>  |
|                | <p>Reviewed By:<br/>V. Geza, PharmD</p> <p><i>[Signature]</i></p> <p><i>[Signature]</i><br/>Labr...<br/>Medical Assistant</p>   |

|   |            |                           |                       |
|---|------------|---------------------------|-----------------------|
| HOSPITAL OR MEDICAL FACILITY  | STATUS     | DEPART./SERVICE           | RECORDS MAINTAINED AT |
| SPONSOR'S NAME  | SSN/ID NO. | RELATIONSHIP TO SPONSOR   | <i>McKean</i>         |
| PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.) |            | REGISTER NO.<br>26864-039 | WARD NO.              |

Kelly, Leslie

## CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

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FIRM (41 CFR) 201-9.202-1

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

1-23-04 0820/10 AM Early to 12 noon - facing Epilepsy, Wife's  
 Denies Hx Trauma; Photophobia & Phonophobia  
 Denies Vision or Δ's, HL, Dizzy, GI Effects, R/O  
 Currents/beds Motion - Needs several tablets  
 some episodes aura & able pre-empt & early Hx  
 Onset Head & Radiation Neck Shoulder 1st Side  
 Hx Benign (suspected) but of relief & Meds  
 L - Hx Rhinorrhea/allergies  
 No 2° LT. Orbital/Temporal & Occ. Facial Pa  
 Freq. QD (VS) QOD & occ. TID  
 Denies Hx - HTN, CAD, other Med. Problem  
 CAD X3, PAD, amputatory & cysts  
 Ear - TM's Intact, & Fluid  
 Nose - Edema, Turb, dried mucous debris, mild sinus CT  
 Oral - Dr. dent, & Lacer, & Erythema Tongue 1st Smooth  
 Neck - FRCM, & LA, & TM's, SNT  
 Face - RT Pro's  
 Throat - CN II - XII Gross Intact  
 Eyes - PERRLA, BOMT, & nystagmus  
 (VS) 114/76, 72, 12 Temp 97.6  
 Non Classic Migraines & aura, & Aura; & all  
 Migraine Prophylaxis & Motion Analgesic Acute  
 Jorval 40 mg T PO BID #60 & Ref.  
 Re-Eval. x 1mas - (P. results & Ref. & & other  
 Hx x 1mas & PPRV Epi/Carbam & Timberstan

Robert E. Piotrowski, PA-C  
 FCI McKean

Reviewed By:  
 V. Geza, PharmD

FD-503 (Rev. 4-78)

AUTHORIZED FOR LOCAL REPRODUCTION

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

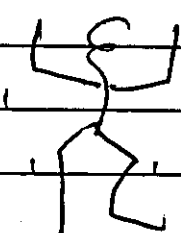

| DATE             | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)  |
|------------------|--|
| 2-20-04<br>-1230 | <p>Requested by Mr. Piotrowski: re-eval for migraine Prophylaxis.</p> <p>HAS TAKEN Imitrex 40mg po BID x 20 days<br/>"It didn't work" Frequency of headaches remained constant.</p> <p>Motrin helps... but HA returns.<br/>Can't see Naproxen b/c upset stomach.</p> <p>Dec 1-8-09 1-30 2-2 2-9<br/>HA onset b/c UNICOR air... doesn't work UNICOR anymore... but<br/>HA's continue</p> <p>① NAD BP = 131/84</p> <p>② HAS</p> <p>③ 1. Pt defiant/angry. Refuses to try more drugs.<br/>Wants to see real doctor. Wants brain scan.</p> <p>2. Referred to Dr. Olson, who, because of duties,<br/>asks that Dr. Beem see him.</p> <p style="text-align: right;"><i>Labrozzi</i><br/>Labrozzi, PA-C<br/>Medical Assistant</p> |

|   |            |                         |                                     |
|---|------------|-------------------------|-------------------------------------|
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| SPONSOR'S NAME  | SSN/ID NO. | RELATIONSHIP TO SPONSOR |                                     |
| PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.) |            | REGISTER NO.            | WARD NO.                            |

Kelly, Leslie

26864-039

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| DATE             | SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)   |
|------------------|--|
| 2/22/04<br>13304 | <p>S/ 41yo with headache everyday for 1/2 year - 3 hours a day. don't wake up at night. Tried anti hypertensive <sup>meds</sup> x/no-works. 0) NSAIDS Help. Look ok. 200# Symmetric Cranial. P70 110/80 P70 - get Anna -</p>  <p>He has Aspirin which helps</p> |
| A/               | <p>Headache - uncertain etiology possibly migraine</p>   |
| P/               | <p>PTed: use med (ASA) start exercising. I'll ask Dr Olson to P74</p>  |
|                  | <p><br/>H. BEAM, MD<br/>FCI MCKEAN</p>  |

7548-99-434-4176

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## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

8/28/03 0915- (5) c/o H/A states has had H/A's  
 off & on x 4 mo. relieved & motion  
 Pain 1-10 scale.

(6) NAD 974 118/68 laughing, happy  
 PERL & sinus tenderness

(7) H/A

(P) 1) Motrin 800 mg po TID prn  
 food # 20NR

(2) Educated on Rx, H/A, plan  
 of care

3) 7/1 in 2 wks, sooner if  
 symptoms J. Glenn CRNP

Steven Labrozzi, RPh  
 Pharmacist

9/26/03  
 1230

9

Inmate received  
 pages of  
 medical records

T. Petrucci #17

T. Petrucci, PMT

HOSPITAL OR MEDICAL FACILITY

STATUS

DEPART./SERVICE

RECORDS MAINTAINED AT  
FCI McKean

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SSN/ID NO.

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PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex;  
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26864-039

Kelly, Leslie

## CHRONOLOGICAL RECORD OF MEDICAL CARE

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DATE

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

10/16/03

0900

SS C/O same H/A off and on as noted previously x 2  
states wants refill of insulin.

C/O chest pain. states pain x 4-M. upper @ chest conditions  
has to use relax techniques to breathe. No pain at this time  
no pain to deep breathe.

O: NAD pulse 80

Heart: normal

Lungs: normal

H/BENT normal

A: C/O H/A etiology?

(2) deep pain 2° anxiety

P: C/O relaxation techniques - education - it understands.

(2) Alleviate

(3) Insulin 800mg q/d PRN dipine #8 R-3

(4) ECG -

Reviewed by:  
V. Geza, PharmD

Eric Asp

Eric Asp  
PA-C

Eric Asp  
PA-C

12/18/03

0850

SS C/O H/A - same as previous visit

C/O sinus problems. No allergies & C/O bleeding when  
blows her nose.

O: NAD

H/BENT: (1) signs of nasal passage, sinus.

Lungs: CTA bilateral - normal

A: H/A - chronic (2) sinus congestion

P: (1) advised q/d AID dipine #15 R-0

(2) Mucin 500mg q/d AID PRN dipine #20 R-0

(3) saline nasal spray # puffs AID dipine #1 R-0

(4) Education - for PRN - it understands.

Reviewed by:  
V. Geza, PharmD

Eric Asp

Eric Asp  
PA-C

| DATE    | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)  |
|---------|--|
| 6-13-03 | "EMERGENCY" SICK CALL  |
| 0630    | <p>⑤ 90% "COLD": cough = keeps in room. Phlegm is yellow body aches, nose stuffed up - can't breathe. X 2 days</p> <p>90% Naproxen upsetting stomach: see 6/9/03</p> <p>⑥ NAB T = 101.2 F Pulse = 100.0 bpm<br/>         SpO<sub>2</sub> = 94% HR = 100 BP = 117/77</p> <p>⑦ tenderness to palp of maxillary sinuses<br/>         HEENT: Otolaryngology<br/>         Oropharynx: not visualized: IM could not position tongue properly<br/>         and attempt: Dexamethasone, ⑧ acetaminophen.</p> <p>LABS: CTA</p> <p>⑧ URE. Sinusitis. [Foot Pain NAs: see 6/9/03]</p> <p>⑨ 1. Plc Naproxen<br/>         2. Motrin 800mg Tpo TID c food/milk #21 Rx3<br/>         3. Amoxicillin 500mg Tpo BID x 14 days #21 Rx1<br/>         4. Gexifencin - dim Tpo c water BID. #14 NR<br/>         5. CTA 4mg Tpo QID prn nasal stuffiness would stop. #20 Rx1.</p> <p>6. IM to Proctor/Motrin intake. ↑ sub. E43V30</p> <p>7. IDLE x 2 days</p> <p>8. IM undetectable to HPLC prn</p> <p>6/13/03<br/>         Reviewed By: [Signature]<br/>         V. Geza, PharmD</p> <p>Steven Labrozzi, PA-C<br/>         Physician Assistant</p> |
| 7-11-03 | Original copies were shredded in error. Please maintain copies on record.  |
| 1400    | <p>Dem. Tan</p> <p>D. Tanner, HIT</p>  |

NSN 7540-00-834-4778

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

AUTHORIZED FOR LOCAL REPRODUCTION

| DATE  | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)   |
|---|---|
| 6/2/03<br>0950  | <p>states around temples. States last couple of months off and on. States that different levels. Under ASH to some relief -</p> <p>O: NAD</p> <p>HEENT: wnl, PETELLA, COME, funduscopy, normal</p> <p>Lungs: CTA - bilaterally</p> <p>Heart: RRR 5 murmurs</p> <p>A: HA 2° w/ser pressure,</p> <p>I: 1) Education - HA avoidance, relief. It underlines</p> <p>2) Acetaminophen 750 mg TID PRN dyspnea #15 R-D</p> <p>3) Ibuprofen 800 mg TID PRN dyspnea #15 R-D</p> <p>4) Plav PRN</p> <p>6/2/03<br/>Reviewed By: (Signature) V. Geza, PharmD</p> <p>Eric Asp<br/>FAC</p>                                 |
| 6/9/03<br>0845  | <p>4) Foot Pain x 10 days.</p> <p>PMN: aching, left medial foot. 10/10 at worst now, best is 4/10.</p> <p>IM bought non-bop boots at commissary. &amp; these have ↓ foot pain</p> <p>6) NAD. Feet: Left arch 2.5 cm high → prominence of medial tarsal bone, not seen on Rt foot... Site of pain when palpated.</p> <p>Right Arch 1.5 cm high.</p> <p>6/9/03<br/>Reviewed By: (Signature) V. Geza, PharmD</p> <p>1. Naproxen 550mg TID BID for foot pain, HA #20 R-D</p> <p>2. Arch Supports (Size 10.5). IM told: No relief x 1 yr. Expect eg/ thick/loss. Relies in</p> <p>3. IM underlined. Eric asp</p> |
| <p>HOSPITAL OR MEDICAL FACILITY 1 yr upon exchange STATUS with old arches. DEPART./SERVICE Steven Labrozzi, PA-C FCI McKean</p> <p>SPONSOR'S NAME RELATIONSHIP TO SPONSOR Physician Assistant</p> |   |
| <p>PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle, ID No or SSN; Sex; REGISTER NO. 26864-039 WARD NO.</p>  |   |

Lelly, Leslie

CHRONOLOGICAL RECORD OF MEDICAL CARE  
 Medical Record

STANDARD FORM 600 (REV. 6-97)  
 Prescribed by GSA/ICMR  
 FPMR (41 CFR) 201.9.202-1

| DATE  | SYMPTOMS, DIAGNOSIS, TREATMENT   | TREATING ORGANIZATION (Sign each entry) |
|---|--|---|
| 9/16/02<br>0310   | ST on c6 blister on the new healing<br>thrust is infected<br>o let wound heal @ good to @ skin<br>o open lesion healed blister with @ infected<br>A blister healed<br>p No Tinet used of red keep with<br>o @ Case Cleared toward Rtc. PA  |   |
| 1/7/03<br>0840  | 40 lesion on hand x 6 months @ pruritus<br>⑤ 40 skin problem on feet x 6 months<br>④ itching ④ bleed. ④ pain.  | Montgomery, MLP                         |
|   | 40 No BM x 3 days. Took "powder stuff" from<br>compression Sunday x 1 dose [metamucil] "It doesn't<br>work"<br>usual bowel habit is QD. Venous abdominal discomfort.   |   |
| 1/7/03<br>Vibelle Goza, PharmD, RPh<br>Chief Pharmacist | ① Hypertrophy areas on feet. ④ xerosis ④ scaling on some<br>④ lesion, dark brown on 2nd & 3rd fingers, side "OVER"<br>① 1. consolidation<br>2. Tinea Pedis & Xerosis<br>3. Psoriasis, rt hand<br>① 1. Biacetyl 5mg 3 tabs qd HS x 1 dose. #3 NK<br>Do not crush or chew, or<br>take w/ antacid.<br>2. Tolnaftate 1% Cream Apply to cleaned & dried<br>skin areas BID #1 R x 3<br>3. Toluene Cream 0.1% Apply sparingly to affected<br>hand area 2-3 x daily #1 R x 1<br>4. Continue to take Metamucil - must be used continuously<br>for effect<br>T increase intake & plant fiber intake. T exercise<br>5. Use lotion on feet.<br>6. Tm unknown Tm plan<br>7. Rtc. per via Sic. |   |

Reviewed by D. Olson, MD  
Date 1/7/03

Labrozzi

SH 7540-00-834-4178

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

| DATE            | SYMPTOMS, DIAGNOSIS, TREATMENT  | TREATING ORGANIZATION | Sign each entry |
|-----------------|---|-----------------------|-----------------|
| 7/30/02<br>0930 | ⑤ c/o nasal congestion, sore throat, mild uncomplicated cough x 1 wk. Joints pain |                       |                 |
|                 | ⑥ NAD 976   |                       |                 |
|                 | eyes - conjunctiva clear  |                       |                 |
|                 | nose - clear drainage, pink membrane  |                       |                 |
|                 | throat - mild erythema & exudate  |                       |                 |
|                 | Lungs - CTA w/ wheezes  |                       |                 |
|                 | ⑦ URT vs allergy  |                       |                 |
|                 | ⑧ 1) CTM 4mg $\frac{1}{2}$ po TID PRN #30 NR                                      |                       |                 |
|                 | 2) Tylenol 325mg $\frac{1}{2}$ po q 6-8 PRN #30 NR                                |                       |                 |
|                 | 3) Educated on Rx + plain of use  |                       |                 |
|                 | 4) Flu shot each cell   |                       |                 |
|                 | Reviewed by D. Olson, MD<br>Date 7/31/02  |                       | J. GLENN, CRNP  |

|                 |   |  |                                       |
|-----------------|---|--|---------------------------------------|
| 10/6/02<br>1715 | ③ IM sent by housing officer to HSH APD "abscess tooth"           |  |                                       |
|                 | IM to pain  |  |                                       |
|                 | ④ Peritonsillar abscess, boil, lower middle left molar / gum line |  |                                       |
|                 | ⑤ Dental Infection  |  |                                       |
|                 | ⑥ 1. Submit S/C request to Dental NOW.                            |  |                                       |
|                 | 2. Ibuprofen 400mg 2 po TID. #30 NIS                              |  |                                       |
|                 | 3. IM to watch dental call-back, + follow-up w/b.                 |  |                                       |
|                 |   |  | [6 tabs dispensed from night cabinet] |

Violette G. Williams, PharmD, RPI  
 Chief Pharmacist

|   |            |   |                       |
|---|------------|---|-----------------------|
| HOSPITAL / MEDICAL FACILITY   | STATUS     | DEPT. / SERVICE   | RECORDS MAINTAINED AT |
| SPONSOR / NAME  | SERIAL NO. | RELATIONS-UP TO SERVICE                                   | FCI McKean            |
| PATIENT IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Race/Grade.) |            | Steven Labrozzi, PA-C<br>Physician Assistant<br>26864-039 |                       |

Kelby, Leslie

CHRONOLOGICAL RECORD OF MEDICAL CARE  
Medical Record

STANDARD FORM 600 (REV. 8-97)  
Prescribed by GSA/CI/M  
FPMR (41 CFR) 201-9.202-1

**FEDERAL BUREAU OF PRISON**

Record copy - Transporting Officer; Copy - Health Record (Top page Position one); Copy - Transferring Institution

7/19/02  
1315

FCI/FPC McKean  
Inmate Received this date \_\_\_\_\_  
Medical History (BP-360) Reviewed \_\_\_\_\_  
Evidence Body Lice: Yes/No  
Medications: Yes/No - Given \_\_\_\_\_

C. Todd Montgomery  
AHSA/SMLP

7840-00-034-4178

AUTHORIZED FOR LOCAL REPRODUCTION

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

6-18-02 S: Requesting note for Tx of hemorrhoids  
0945 O: Hemorrhoids by H.  
A:

P: ① Dilucaine ointment PRN as directed  
② Hemorrhoidal Supp. T QD after BM.  
③ P.H. on S.C. PRN.

Martin Newton, PA-C  
USP, Lewisburg

W. Newton, PA-C

HOSPITAL OR MEDICAL FACILITY

STATUS

DEPART./SERVICE

RECORDS MAINTAINED AT

SPONSOR'S NAME

SSN/ID NO.

RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO.

WARD NO.

## CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 8-97)

Prescribed by GSA/ICMR  
FIRM (41 CFR) 201-9.202-1USP LEWISBURG  
HEALTH SERVICES UNIT

KELLY, LESLIE  
26864-039

FEDERAL BUREAU OF PRISON

Current 1. EHM 4. \_\_\_\_\_  
Medical 2. \_\_\_\_\_ 5. \_\_\_\_\_  
Problems 3. \_\_\_\_\_ 6. \_\_\_\_\_

Additional Comments - Blood and Body Fluid Precautions

|  |                              |                        |
|--|------------------------------|------------------------|
| Sign and Print Name - Certifying Health Authority<br><i>Leonard Potter</i> Leonard Potter, EMT-P | Phone Number<br>579-523-1251 | Date Signed<br>4-17-02 |
|--|------------------------------|------------------------|

Record copy - Transporting Officer: Copy - Health Record (Top page Position one); Copy - Transferring Institution

**MEDICAL RECORD**

AUTHORIZED FOR LOCAL REPRODUCTIVE

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

| DATE      | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)   |
|-----------|---|
| 8-3-13-01 | S: Complains of: itching/fungal rash/ minor headache/ dyspepsia/ cough & co. Areas of open lesion 2° Td nasal congestion/constipation/toothache/dandruff/hemorrhoids/diarrhea |
| 1335      | Reaction noted. Swelling noted  |
| 343       | O: Temp: 96.2 BP: Pulse: Resp: Wt: Heart Rate Lung: Abdomen:  |
|           | A: Dermatitis/ Athlete Foot/ Dyspepsia/ Cough/ Nasal Congestion/ Dandruff/ URI/ Constipation/ Minor Headache/ Toothache/ Diarrhea/ Tinea Versicolor                           |
|           | ( ) Clotrimazole 1% Cream: Apply to affected area BID #1  |
|           | ( ) Foot Powder: Use as directed BID #1   |
|           | ( ) Actifed Tablets: Take 1-2 tablets PO every 6 hours. #30   |
|           | ( ) CTM 4mg Tablets: Take 1 tablet TID (for patients with HTN & diabetes)   |
|           | ( ) Humibid DM: Take 1 tablet BID #10   |
|           | ( ) Salines Nasal Sprav: Use 1-2 puffs INO 2-3 times a day.   |
|           | ( ) Diphenhydramine 25mg Caps: Take 1-2 caps TID #30  |
|           | ( ) Hydroxyzine 25mg Tabs: Take 1-2 tabs PO TID #30   |
|           | ( ) Hydrocortisone 1% Cream: Apply to affected area TID #1  |
|           | ( ) Selsnium Sulfide 2% Soln: Use as Directed #1  |
|           | ( ) Vitamin A&D Oint: Apply to affected area BID #1   |
|           | ( ) Domoboro Tablets: Use as directed #12   |
|           | ( ) Tylenol 325mg Tab: Take 1-2 tablets PO Q4-6H-PRN #24  |
|           | ( ) Motrin 600mg Tab: Take 1 tablet PO TID #21  |
|           | ( ) Dibucaine Oint: Apply to affected area as directed BID #1   |
|           | ( ) Hemorrhoidal HC Supp: Unwrap and use 1 Supp. as directed #12  |
|           | ( ) Maalox Plus Liq: Take 1-2 Tablespoonsfull PO PC & HS #1   |
|           | ( ) Simethicone 80mg Chew Tab: Chew 1-2 tabs PO PC & HS #60   |
|           | ( ) Gaviscon Tabs: Chew 1-2 tabs AC & HS #60  |
|           | ( ) Docusate Sod. 100mg Cap: Take 1 Capsule PO BID #14  |
|           | ( ) Psyllium Powder: Take 1 teaspoonful PO TID #1   |
|           | ( ) MOM: Take 1 tablespoonsful PO TID 120ml   |
|           | ( ) Biscadoyl 5mg Tab: Take 1 tab BID #6  |
|           | ( ) Loperamide 2mg Cap: Take PO as directed 4caps/24hours and 8caps/2days.  |
|           | Patient instructed and understands indications/side effects of issued medication  |
|           | Referred to Dentist   |

|   |            |                         |                       |
|---|------------|-------------------------|-----------------------|
| HOSPITAL OR MEDICAL FACILITY  | STATUS     | DEPART./SERVICE         | RECORDS MAINTAINED AT |
| S R HEALTH SERVICES ATLANTA   |            |                         |                       |
| SPONSOR'S NAME  | SSN/ID NO. | RELATIONSHIP TO SPONSOR |                       |
|   |            |                         |                       |
| PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.) |            |                         | REGISTER NO.          |
|   |            |                         | WARD NO.              |

Kelly, Lester  
26864-039

CHRONOLOGICAL RECORD OF MEDICAL CARE  
Medical Record

STANDARD FORM 600 (REV. 6-97)  
Prescribed by GSA/ICMR  
FIRM (41 CFR) 201-9.202-1

DATE SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

11/27/01 10:20 AM J. 28 year old BR. complains of having a lump in his groin. Couple of days ago. NKDA. He wants to be evaluated today.

① Physical Examination: Cooperative. RR: 18, SpO<sub>2</sub>: 98.2%. General Appearance: Good. Right Inguinal Infection - left, tender, non-ulcerative, tender. No palpable mass noted. Form by a full.

A. Ab. Tenderness. Inguinal Infection

P. Patient's source - TB is clinic if how is any unusual? No understanding of training from gym - or for weight lifting. ALAMA, FERDINAND N., PA

1/8/02 1020 S: C/o hurting throat, cough, stuffy nose. O: T: 97.6. Throat is congested and inflamed. Lungs are clear on auscultation.

A: 1) Pharyngitis. 2) URI 3) Constipation

P: 1) Tabs acetified. Tid #15.

2) Tabs Pen VK 250mg Tid x 10 days

3) Bisacodyl tabs 5mg. Tid x 3 days

It Ed: Drink plenty of fluids.

Tx and follow up discussed and understood. RTC PRN

J. Okoth - MLP

Jane Okoth, MLP

440-00-834-4178

AUTHORIZED FOR LOCAL REPRODUCTION

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

11-21-01

Admin Note:

1906 0700 WTB

1250

1/1M c/o pain @ groin. Onset 2 days ago p riding exercise bike. States pain is sharp, non-radiating. Felt "lump" at pain site yesterday, but lump has gone down today. Denies urinary symptoms, fever, N/V, sweating. BM's normal.

Denies PMH, MEDS, ALL.

PE: ~~IM~~ found ambulating = difficulty, NAL A&A 0x3. Skin WPD. Resp @ expansion, non-labored. Abd SNT. Slight tenderness @ groin. MAE well & adequate sensation. Strong radial pulses.

Tx: Spoke to Dr. Salam who ordered rest, idle. May return to work Mon. 11/26/01. motion soc y thru t day BPrince REMT  
in null after usual 30 Tablet

Beverly Prince, EMT-P

Ord. Date

KELLY, LESLIE ROMILE

A. SALAM

Exp. Date

26864-039

(0) Refills

11/30/01

TAKE ONE TABLET 3 TIMES A DAY AFTER MEALS

Rx #

56426

IBUPROFEN 800 MG TAB

#30

Ahmed S. Abdel-Salam, M.D.

HOSPITAL OR MEDICAL FACILITY

USP LEWISBURG

STATUS

DEPART./SERVICE

RECORDS MAINTAINED AT

SPONSOR'S NAME

HEALTH SERVICES UNIT  
LEWISBURG, PA 17837

SSN/ID NO.

RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO.

26864-039

WARD NO.

Kelly, Leslie

CHRONOLOGICAL RECORD OF MEDICAL CARE  
Medical Record

STANDARD FORM 600 (REV. 8-97)  
Prescribed by GSA/ICMR  
FIRM (41 CFR) 201-9.202-1

7546-00-834-4178

unavailable

1491113A9110 6.5  
AUTHORIZED FOR LOCAL REPRODUCTION

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

| DATE          | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)  |
|---------------|--|
| 4/16/01<br>10 | <p>S: C/o Painfull (R) elbow joint accompanied by cracking sound when flexing the elbow.<br/>Hx of fractured R elbow 2 yrs ago<br/>Also c/o cold and sore throat<br/>O: throat is inflamed mildly and congested.<br/>Elbow is not swollen and has full ROM. except for limitation of extension.</p> <p>A: 1) Pharyngitis (viral)<br/>2) DTD (R) elbow<br/>3) X-Ray (R) elbow:<br/>4) Indomethacin 25 mg T tid #30<br/>5) Tabs acetified T tid #15<br/>H Ed: Drink plenty of water.</p> <p>APR 16 2001<br/>Abraham Rader-Saleh, M.D.</p> <p>Ord. Date 04/16/01 KELLY, LESLIE ROMILE J. OKOTH<br/>26864-039<br/>Exp. Date 04/25/01 TAKE ONE CAPSULE 3 TIMES A DAY<br/>AFTER MEALS</p> <p>Rx # 38006 INDOMETHACIN 25 MG CAP # 30</p> <p>Ord. Date 04/16/01 KELLY, LESLIE ROMILE J. OKOTH<br/>26864-039<br/>Exp. Date 04/20/01 TAKE ONE TABLET 3 TIMES A DAY</p> <p>Rx # 38007 TRIPROLIDINE/PSEUDOEPHED # 15</p> <p>JANE. F. OKOTH</p> |

|   |            |                         |                       |
|---|------------|-------------------------|-----------------------|
| HOSPITAL OR MEDICAL FACILITY:<br>USC LEWISBURG<br>Health Services Unit  | STATUS     | DEPART./SERVICE         | RECORDS MAINTAINED AT |
| SPONSOR'S NAME<br>Lewisburg PA 17037  | SSN/ID NO. | RELATIONSHIP TO SPONSOR |                       |
| PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.) |            | REGISTER NO.            | WARD NO.              |

Kelly, ~~Leslie~~ Leslie  
error 501

## CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 6-97)  
Prescribed by GSA/ICMR  
FIRMR (41 CFR) 201-9.202-1

DARL4-039

| DATE                   | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)  |
|------------------------|--|
| 4/23/01<br>1035        | <p>S: C/o a bump under his arm<br/>x several weeks (painful)</p> <p>O: Has a skin tag ~ 6 mm long<br/>in left axillary area.</p> <p>A: Skin tag @ axilla.</p> <p>P: 1) Excise skin tag.</p> <p>Pt Ed: Watch call out for<br/>skin tag excision.</p> <p><i>[Signature]</i> PA<br/>Jane Okoth, PA</p>  |
| 11/8/09<br>1018<br>SLC | <p>S: @ 38 y/o c/o of chest pain + 1 day ago<br/>shot last po second. Denies, at that time any<br/>dizziness, armors, vomiting or diarrhea, fever -<br/>also no difficulty breathing any more times. 96<br/>pain happen when taking a shower. It has<br/>increased &amp; it &amp; pain occur during running<br/>or physical exertion. Pt w/o h/o cardiac<br/>problem. Mother is diabetic.</p> <p>O: Ambulatory, oriented x2 &amp; appears well. -<br/>HEENT - O c/o sinus, &amp; diaphragm &amp; pulmonary<br/>chest clear &amp; w/chi, &amp; rals &amp; wheezes, &amp; normal<br/>abd. exam.</p> <p>set. O c/o sinus &amp; hypoxia or hypoxemia.</p> <p>vs: BP 12/65 HR 69 Temp 98.5</p> <p>AO r/o ECG</p> <p>P: P.E. @ contact with clinician inf symptoms</p> <p>① Pt under test</p> <p><i>[Signature]</i><br/>Ivan Navarro, P.A.</p> |

## MEDICAL RECORD

## CHRONOLOGICAL RECORD OF MEDICAL CARE

| DATE            | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)   |
|-----------------|---|
| 3/30/01<br>1245 | S: This 28 y/o BM came in for FOOD HANDLER'S EXAMINATION.<br>Do you have any recent or chronic skin infection? <input type="checkbox"/> Yes or <input checked="" type="checkbox"/> No<br>Do you have any recent or chronic intestinal infection? <input type="checkbox"/> Yes or <input checked="" type="checkbox"/> No<br>Do you have any recent or chronic diseases of the respiratory system (except asthma)? <input type="checkbox"/> Yes or <input checked="" type="checkbox"/> No<br>Do you have or have you ever had any sexually transmitted disease? <input type="checkbox"/> Yes or <input checked="" type="checkbox"/> No<br>Do you have or have you ever had any type of hepatitis? <input type="checkbox"/> Yes or <input checked="" type="checkbox"/> No<br>Do you have or have you ever had tuberculosis? <input type="checkbox"/> Yes or <input checked="" type="checkbox"/> No<br>Have you tested positive for HIV? <input type="checkbox"/> Yes or <input checked="" type="checkbox"/> No<br>Do you think you may have any other communicable diseases? <input type="checkbox"/> Yes or <input checked="" type="checkbox"/> No<br>O: VS: Bp: 145/96 HR 98 Temp 98.2° F Wt 200 lb. ht 5'11"<br>Skin: Open wounds, Infections, Rashes: <input checked="" type="checkbox"/> Absent <input type="checkbox"/> Present<br>Comments: None<br>Lungs: Rhonchi, Rales, Crackles, Diminished Breath Sounds: <input checked="" type="checkbox"/> Absent <input type="checkbox"/> Present<br>Comments: None<br>Abdomen: Organomegaly, Tenderness: <input checked="" type="checkbox"/> Absent <input type="checkbox"/> Present<br>A: ESSENTIALLY HEALTHY MALE<br>P: <input checked="" type="checkbox"/> CLEARED for Food Services<br><input type="checkbox"/> NOT CLEARED for food Services |

Luis Ramirez, P.A.

Luis Ramirez, P.A.

|                           |            |                         |                    |
|---------------------------|------------|-------------------------|--------------------|
| PITAL OR MEDICAL FACILITY | STATUS     | DEPART./SERVICE         | RECORDS MAINTAINED |
| SPONSOR'S NAME            | SSN/ID NO. | RELATIONSHIP TO SPONSOR |                    |

ENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO.  
26864-039

WARD N

Kelly, Leslie  
DCA - 11/17/60

CHRONOLOGICAL RECORD OF MEDICAL  
Medical Record  
STANDARD FORM 600 (REV. 6-97)  
Prescribed by GSA/CMR

USP LEWISBURG  
HEALTH

**AUTHORIZED FOR LOCAL REPRODUCTION**

## CHRONOLOGICAL RECORD OF MEDICAL CARE

**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)**

S. I/O complains of runny nose. No other symptoms referred.

①. Nasal congestion noted. Clear secretion noted  
1A - ① Allergic rhinitis

P. ① Actified ÷ Lab P.O. TLD x 5d. #15

② pt. educ. (Tx. and Rx. use were explained. Pt. understood. F/u PRN). Luis Ramirez

Luis Ramirez, P.A.  
Luis Ramirez, P.A.

| STATUS |
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DEPART./SERVICE

RECORDS MAINTAINED AT

SPONSOR'S NAME

SSN/ID NO.

| RELATIONSHIP TO SPONSOR        |
|--------------------------------|
| 1. Name of sponsor             |
| 2. Name of subject             |
| 3. Address of subject          |
| 4. Date of birth               |
| 5. Date of entry into U.S.     |
| 6. Date of departure from U.S. |
| 7. Date of return to U.S.      |
| 8. Date of death               |
| 9. Date of arrest              |
| 10. Date of release            |
| 11. Date of conviction         |
| 12. Date of sentencing         |
| 13. Date of appeal             |
| 14. Date of final judgment     |
| 15. Date of parole             |
| 16. Date of probation          |
| 17. Date of discharge          |
| 18. Date of reentry            |
| 19. Date of re-arrest          |
| 20. Date of re-sentencing      |
| 21. Date of re-appeal          |
| 22. Date of re-final judgment  |
| 23. Date of re-parole          |
| 24. Date of re-probation       |
| 25. Date of re-discharge       |
| 26. Date of re-entry           |
| 27. Date of re-arrest          |
| 28. Date of re-sentencing      |
| 29. Date of re-appeal          |
| 30. Date of re-final judgment  |
| 31. Date of re-parole          |
| 32. Date of re-probation       |
| 33. Date of re-discharge       |
| 34. Date of re-entry           |
| 35. Date of re-arrest          |
| 36. Date of re-sentencing      |
| 37. Date of re-appeal          |
| 38. Date of re-final judgment  |
| 39. Date of re-parole          |
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| 44. Date of re-sentencing      |
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| 63. Date of re-parole          |
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| 82. Date of re-entry           |
| 83. Date of re-arrest          |
| 84. Date of re-sentencing      |
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| 87. Date of re-parole          |
| 88. Date of re-probation       |
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| 90. Date of re-entry           |
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| 92. Date of re-sentencing      |
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| 94. Date of re-final judgment  |
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| 108. Date of re-sentencing     |
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| 110. Date of re-final judgment |
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| 124. Date of re-sentencing     |
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| 146. Date of re-entry          |
| 147. Date of re-arrest         |
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| 150. Date of re-final judgment |
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| 153. Date of re-discharge      |
| 154. Date of re-entry          |
| 155. Date of re-arrest         |
| 156. Date of re-sentencing     |
| 157. Date of re-appeal         |
| 158. Date of re-final judgment |
| 159. Date of re-parole         |
| 160. Date of re-probation      |
| 161. Date of re-discharge      |
| 162. Date of re-entry          |
| 163. Date of re-arrest         |
| 164. Date of re-sentencing     |
| 165. Date of re-appeal         |
| 166. Date of re-final judgment |
| 167. Date of re-parole         |
| 168. Date of re-probation      |
| 169. Date of re-discharge      |
| 170. Date of re-entry          |
| 171. Date of re-arrest         |
| 172. Date of re-sentencing     |
| 173. Date of re-appeal         |
| 174. Date of re-final judgment |
| 175. Date of re-parole         |
| 176. Date of re-probation      |
| 177. Date of re-discharge      |
| 178. Date of re-entry          |
| 179. Date of re-arrest         |
| 180. Date of re-sentencing     |
| 181. Date of re-appeal         |
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| 183. Date of re-parole         |
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| 187. Date of re-arrest         |
| 188. Date of re-sentencing     |
| 189. Date of re-appeal         |
| 190. Date of re-final judgment |
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| 200. Date of re-probation      |
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| 202. Date of re-entry          |
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| 205. Date of re-appeal         |
| 206. Date of re-final judgment |
| 207. Date of re-parole         |
| 208. Date of re-probation      |
| 209. Date of re-discharge      |
| 210. Date of re-entry          |
| 211. Date of re-arrest         |
| 212. Date of re-sentencing     |
| 213. Date of re-appeal         |
| 214. Date of re-final judgment |
| 215. Date of re-parole         |
| 216. Date of re-probation      |
| 217. Date of re-discharge      |
| 218. Date of re-entry          |
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| 223. Date of re-parole         |
| 224. Date of re-probation      |
| 225. Date of re-discharge      |
| 226. Date of re-entry          |
| 227. Date of re-arrest         |
| 228. Date of re-sentencing     |
| 229. Date of re-appeal         |
| 230. Date of re-final judgment |
| 231.                           |

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO.

26864-039

WARD NO.

U.S. DEPARTMENT OF  
HEALTH, EDUCATION &  
WELFARE

### CHRONOLOGICAL RECORD OF MEDICAL CARE

### Medical Record

**STANDARD FORM 600 (REV. 6-97)**  
Prescribed by GSA/ICMR  
FIRM (41 CFR) 201-9.202-1

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION/Sign each entry

3-2-01  
1325  
343

S: Complains of: itching/fungal rash/ minor headache/ dyspepsia/ cough & cc nasal congestion/constipation/toothache/dandruff/hemorrhoids/diarrhea

O: Temp: BP: Pulse: Resp. Wt:  
Heart Rate Lung: Abdomen:

A: Dermatitis/ Athlete Foot/ Dyspepsia/ Cough/ Nasal Congestion/ Dandruff/

URI/ Constipation/ Minor Headache/ Toothache/ Diarrhea/ Tinea Versicolor

( ) Clotrimazole 1% Cream: Apply to affected area BID #1

( ) Foot Powder: Use as directed BID #1

( ) Actified Tablets: Take 1-2 tablets PO every 6 hours. #30

( ) CTM 4mg Tablets: Take 1 tablet TID (for patients with HTN & diabetes

( ) Humibid DM: Take 1 tablet BID #10

( ) Salines Nasal Spray: Use 1-2 puffs INO 2-3 times a day.

( ) Diphenhydramine 25mg Caps: Take 1-2 caps TID #30

( ) Hydroxyzine 25mg Tabs: Take 1-2 tabs PO TID #30

( ) Hydrocortisone 1% Cream: Apply to affected area TID #1

( ) Selsnium Sulfide 2% Soln: Use as Directed #1

( ) Vitamin ASD Oint: Apply to affected area BID #1

( ) Domoboro Tablets: Use as directed #12

( ) Tylenol 325mg Tab: Take 1-2 tablets PO Q4-6H-PRN #24

( ) Motrin 600mg Tab: Take 1 tablet PO TID #21

( ) Dibucaine Oint: Apply to affected area as directed BID #1

( ) Hemorrhoidal HC Supp: Unwrap and use 1 Supp. as directed #12

( ) Maalox Plus Liq: Take 1-2 Tablespoonsfull PO PC & HS #1

( ) Simethicone 80mg Chew Tab: Chew 1-2 tabs. PO PC & HS #60

( ) Gaviscon Tabs: Chew 1-2 tabs AC & HS #60

( ) Docusate Sod. 100mg Cap: Take 1-Capsule PO BID #14

( ) Psyllium Powder: Take 1 teaspoonful PO TID #1

( ) MOM: Take 1 tablespoonsful PO TID 120ml

( ) Biscadoyl 5mg Tab: Take 1 tab BID #6

( ) Loperamide 2mg Cap: Take PO as directed 4caps/24hours and 8caps/2days

Patient instructed and understands indications/side effects of issued medicar

Referred to Dentist

*[Signature]*  
W. WILLIAMS, M.D.  
USP ATLANTA

HOSPITAL OR MEDICAL FACILITY

STATUS

DEPART./SERVICE

RECORDS MAINTAINED AT

SPONSOR'S NAME

USP HEALTH SERVICES ATLANTA

SSN/ID NO.

RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION

(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO.

WARD NO.

Lester, Kelly  
26804-039

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 6-97)  
Prescribed by GSA/ICMR  
FIRM (41 CFR) 201-9.202-1

TEL 334-6944

P. 002



TS Clearance ☐ Yes ☐ No

1) PPD Completed: 01-16-01  
Date

Results: 0

2) CXR Completed: \_\_\_\_\_  
Date

3) Health Authority  
Clearance: 1-17-01  
1-17-01

Sign \_\_\_\_\_ Date \_\_\_\_\_

Note:  
Daxer listed above must be  
within one year of this transfer.

0

|  |   |  |                         |
|--|---|--|-------------------------|
| Is prisoner medically able to travel by BUS, VAN or CAR?   | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No            | If no, Why not?         |
| Is prisoner medically able to travel by airplane?  | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No            | If no, Why not?         |
| Is prisoner medically able to stay overnight at another facility en route to destination?        | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No            | If no, Why not?         |
| Is there any medical reason for restricting the length of time prisoner can be in travel status? | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | If yes, state reason:   |
| Does prisoner require any medical equipment while in transport status?                           | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | If yes, What equipment? |

**Phone Numbers:**

**Date Signed:**

C JOHNSON LPN

Phone Number: 334-580-2529 Date Signed: 01-16-01

Form USM-552  
(Rev. 6-9-81)

Medication  
Complaint

M. Mercedes, MLP  
USP Atlanta

REVIEW

Ivan Negrón  
Physician

B-1481- 1950

U.S.P. ATLANTA  
OK FOR TRANSFER

U.S.P.  
UST

With medication: Serenaf - 25mg Tab 1 CAPSULE  
7am, 12N, 7pm HPIRE - 323-01-

USP Lewisburg

Inmate Received, this date 3/19/01

|                                  |        |
|----------------------------------|--------|
| Medical History Reviewed         | Yes No |
| Evidence of lice                 | Yes No |
| Suicidal Thoughts                | Yes No |
| Recent Assault, Trauma or Abuse  | Yes No |
| Signs and Symptoms of Infect Dse | Yes No |
| Allergies to Medications         | Yes No |
| Medications                      | Yes No |

*[Signature]*

Ivan Navarro, P.A.

1930

Yes No

**U.S. MEDICAL CENTERS FOR FEDERAL PRISONERS**  
**Laboratory, 1900 W. Sunshine**  
**SPRINGFIELD, MISSOURI 65808**  
**(417) 862-7041**

\*\*\* SENSITIVE-LIMITED OFFICIAL USE \*\*\*  
**FINAL REPORT**

Register Number : 26864-039  
 Name : KELLY, LESLIE  
 Location : FCI JESUP (JES)  
 Admit. Physician: WICKARD  
 Order. Physician: WICKARD  
 Collected : 10/03/05 @ 09:30 by: RE

Age : 42yr  
 Sex : M  
 Room :  
 Accession Number : 9350

| Test   | Result | Flag | Reference Range/Units           | Tech  |
|--|--------|------|---------------------------------|-------|
| <b>LIPID TESTING</b>   |        |      |                                 |       |
| <b>COMP. METABOLIC</b>   |        |      |                                 |       |
| Glucose  | 88     |      | 70 - 110 mg/dL                  | CK RY |
| Urea Nitrogen  | 12     |      | 7 - 22 mg/dL                    | CK RY |
| Creatinine   | 1.2    |      | 0.6 - 1.6 mg/dL                 | CK RY |
| SodiumI  | 139    |      | 137 - 148 mmol/L                | CK RY |
| Potassium  | 4.6    |      | 3.5 - 5.0 mmol/L                | CK RY |
| ChlorideI  | 106    |      | 99 - 114 mmol/L                 | CK RY |
| CalciumI   | 9.5    |      | 8.5 - 10.9 mg/dL                | CK RY |
| Total Protein  | 7.2    |      | 6.0 - 8.2 g/dL                  | CK RY |
| Albumin  | 4.1    |      | 3.6 - 5.1 g/dL                  | CK RY |
| Alkaline Phos.   | 83     |      | 41 - 133 U/L                    | CK RY |
| AST(SGOT)  | 17     |      | 11 - 55 U/L                     | CK RY |
| Total BilirubinI   | 0.3    |      | 0.2 - 1.3 mg/dL                 | CK RY |
| Cholesterol  | 220    | HI   | 140 - 200 mg/dL                 | CK RY |
| Triglycerides  | 74     |      | 30 - 200 mg/dL                  | CK RY |
| ALT1(SGPT)   | 30     |      | 11 - 66 U/L                     | CK RY |
| HDL-CholesterolI   | 48     |      | 29 - 67 mg/dL                   | JN RY |
| Other factors critical to assessment of<br>CHD risk - Overweight, Blood Pressure,<br>Smoking and Familial History. |        |      |                                 |       |
| VLDL   | 15     |      | mg/dL                           | HS RY |
| LDL Cholesterol  | 157    | HI   | 62 - 130 mg/dL                  | HS RY |
| Chol/HDL Ratio   | 4.6    |      | 3.4 - 5.0                       | HS RY |
| TSH  | 1.050  |      | 0.465 - 4.680 uIU/mL            | JE RY |
| <b>CBC</b>   |        |      |                                 |       |
| White Blood Cell   | 6.5    |      | 4.3 - 11.1 10 <sup>3</sup> /uL  | RS RY |
| Red Blood Cells  | 5.48   |      | 4.46 - 5.78 10 <sup>6</sup> /uL | RS RY |
| Hemoglobin   | 15.3   |      | 13.6 - 17.6 g/dL                | RS RY |
| Hematocrit   | 46.4   |      | 40.2 - 51.4 %                   | RS RY |
| MCV  | 84.5   |      | 82.5 - 96.5 fL                  | RS RY |
| MCH  | 27.9   |      | 27.1 - 34.3 pg                  | RS RY |
| MCHC   | 33.0   |      | 33.0 - 35.0 g/dL                | RS RY |
| RDW  | 15.9   | HI   | 12.0 - 14.0 %                   | RS RY |
| PLT  | 222    |      | 130 - 374 10 <sup>3</sup> /uL   | RS RY |

**Legend**

LO-Low AL-Alert Low HI-High AH-Alert High AB-Abnormal

EL-Less than Clinically Reportable Range

EH-Greater than Clinically Reportable Range

Name : KELLY, LESLIE  
 Register Number : 26864-039  
 Printed : 10/04/2005 @ 16:18

10/19  
 M. Chipi, MD  
 Medical Officer  
 FCI Jesup, Ga.

10-19-05  
 Location : JES  
 Page : 1 of 2

U.S. MEDICAL CENTERS FOR FEDERAL PRISONERS  
 Laboratory, 1900 W. Sunshine  
 SPRINGFIELD, MISSOURI 65808  
 (417) 862-7041

\*\*\* SENSITIVE-LIMITED OFFICIAL USE \*\*\*  
 FINAL REPORT

Register Number : 26864-039  
 Name : KELLY, LESLIE  
 Location : FCI JESUP (JES)  
 Admit. Physician: WICKARD  
 Order. Physician: WICKARD  
 Collected : 10/03/05 @ 09:30 by: RE

Age : 42yr  
 Sex : M  
 Room :  
 Accession Number : 9350

| Test         | Result | Flag | Reference Range/Units         | Tech  |
|--------------|--------|------|-------------------------------|-------|
| MPV          | 9.6    |      | 6.9 - 10.5 fL                 | RS RY |
| AUTODIFF     |        |      |                               |       |
| Neutrophils  | 48.7   |      | 43.0 - 67.0 %                 | RS RY |
| Lymphocytes  | 43.2   |      | 21.0 - 45.0 %                 | RS RY |
| Monocytes    | 6.3    |      | 5.0 - 13.0 %                  | RS RY |
| Eosinophils  | 1.7    |      | 0.0 - 7.0 %                   | RS RY |
| Basophils    | 0.1    |      | 0.0 - 1.0 %                   | RS RY |
| Neutrophil # | 3.1    |      | 1.9 - 6.7 10 <sup>3</sup> /uL | RS RY |
| Lymphocyte # | 2.8    |      | 1.3 - 3.7 10 <sup>3</sup> /uL | RS RY |
| Monocyte #   | 0.4    |      | 0.3 - 1.1 10 <sup>3</sup> /uL | RS RY |
| Eosinophil # | 0.1    |      | 0.0 - 0.5 10 <sup>3</sup> /uL | RS RY |
| Basophil #   | 0.0    |      | 0.0 - 0.1 10 <sup>3</sup> /uL | RS RY |

Legend

LO=Low AL=Alarm Low HI=High AH=Alarm High AB=Abnormal

RL=Less than Clinically Reportable Range

EH=Greater than Clinically Reportable Range

Name : KELLY, LESLIE  
 Register Number : 26864-039  
 Printed : 10/04/2005 @ 16:18

10/19  
 M. Chipi, MD  
 Medical Officer  
 FCI Jesup, Ga.

10.19.05 B. Tremu, M.D.  
 Location : JES  
 Page : 2 of 2

BP-S 360.060 HEALTH INTAKE ASSESSMENT/HISTORY

PART 2

HEALTH CARE PROVIDER: Please complete the following:

Kelly, Leslie R.

26864-039

DOB: 12-17-62

FCI Bennettsville

Institution:

FCI  
Bennettsville

## A. INMATE NEEDS FOLLOW-UP FOR THE FOLLOWING: (Provider will review inmate responses and comment where necessary)

| ISSUE OR CONDITION   | COMMENTS (Indicate if urgent treatment is necessary)   |
|--|--|
| Infectious disease: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Draining skin lesions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Signs of lice?: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Signs of scabies?: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Have you had any of the following in the last 3-6 months. <b>NO</b><br>Boils, Spider bites, open lesions |
| <input type="checkbox"/> Skin condition: include trauma markings, bruises, jaundice, recent tattoos, needle marks, or other indications of drug use  |  |
| <input type="checkbox"/> Drug/alcohol withdrawal   |  |
| <input type="checkbox"/> Mental Health Issues  |  |
| <input type="checkbox"/> Pain Management   |  |
| <input type="checkbox"/> Physical disabilities/deformities   |  |
| <input type="checkbox"/> Cardiovascular disease  | <b>Chest + pain</b>  |
| <input type="checkbox"/> Diabetes <b>NO</b>  |  |
| <input type="checkbox"/> Asthma  |  |
| <input type="checkbox"/> Cancer  |  |
| <input type="checkbox"/> Dental problems   |  |
| <input type="checkbox"/> OB/Gyn <b>N/A</b>   |  |
| <input type="checkbox"/> Other:  |  |

## B. OTHER COMMENTS OR PHYSICAL FINDINGS: (Record vital signs if indicated)

|                         |
|-------------------------|
| <b>See 600 for meds</b> |
|                         |
|                         |
|                         |
|                         |
|                         |

C. ☒ MEDICATION AND OTHER ORDERS WRITTEN ON SF-600 FORMD. ☐ MEDICATION CONSENT FORMS SIGNEDE. ☐ INSTRUCTED INMATE HOW TO OBTAIN MEDICAL, DENTAL, AND MENTAL HEALTH SERVICES

|   |   |
|---|---|
| Provider Signature:<br><b>S. Deese RN</b> | Printed Name/Credentials:<br><b>S. Deese, RN, BSN</b> |
| Date:<br><b>12-01-05</b>                  | Time:<br><b>15:55</b>                                 |

(This form may replicated via WP)

This form replaces BP-S360 dtd MAY 94

BP-S 360.060 HEALTH INTAKE ASSESSMENT/HISTORY

PART 2

HEALTH CARE PROVIDER: Please complete the following:

|                                      |                                 |                                      |
|--------------------------------------|---------------------------------|--------------------------------------|
| Inmate Name:<br><i>Kelly, Leslie</i> | Register No:<br><i>26864039</i> | Institution:<br><b>USP - ATLANTA</b> |
|--------------------------------------|---------------------------------|--------------------------------------|

## A. INMATE NEEDS FOLLOW-UP FOR THE FOLLOWING: (Provider will review inmate responses and comment where necessary)

| ISSUE OR CONDITION  | COMMENTS (Indicate if urgent treatment is necessary) |
|---|--|
| Infectious disease: <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| Draining skin lesions: <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| Signs of lice? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| Signs of scabies? <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| <input type="checkbox"/> Skin condition: include trauma markings, bruises, jaundice, recent tattoos, needle marks, or other indications of drug use |  |
| <input type="checkbox"/> Drug/alcohol withdrawal  |  |
| <input type="checkbox"/> Mental Health Issues   |  |
| <input type="checkbox"/> Pain Management  |  |
| <input type="checkbox"/> Physical disabilities/deformities  |  |
| <input type="checkbox"/> Cardiovascular disease   |  |
| <input type="checkbox"/> Diabetes   |  |
| <input type="checkbox"/> Asthma   |  |
| <input type="checkbox"/> Cancer   |  |
| <input type="checkbox"/> Dental problems  |  |
| <input type="checkbox"/> OB/Gyn   |  |
| <input checked="" type="checkbox"/> Other: <i>all frag page (21)</i>  |  |

## B. OTHER COMMENTS OR PHYSICAL FINDINGS: (Record vital signs if indicated)

|  |
|--|
|  |
|  |
|  |
|  |
|  |
|  |

C. ☐ MEDICATION AND OTHER ORDERS WRITTEN ON SF-600 FORMD. ☐ MEDICATION CONSENT FORMS SIGNEDE. ☒ INSTRUCTED INMATE HOW TO OBTAIN MEDICAL, DENTAL, AND MENTAL HEALTH SERVICES

|   |  |
|---|--|
| Provider Signature:<br><i>[Signature]</i> | Printed Name/Credentials:<br><i>R. Ognes, MD</i><br><i>USP Atlanta</i> |
| Date: <i>11/30/05</i>                     | Time: <i> </i>   |

BP-S360.060 HEALTH : TAKE ASSESSMENT/HISTORY

FEB 05

PART 1

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

|   |                                 |  |
|---|---------------------------------|--|
| Inmate Name:<br><u>David Williams</u>   | Register No:<br><u>24264039</u> | Institution:<br><b>USP/FPC Atlanta</b> |
| Inmate Received From: <input type="checkbox"/> Court <input type="checkbox"/> Jail <input type="checkbox"/> Self-surrender <input type="checkbox"/> Parole Violator <input type="checkbox"/> Other _____ To: <input type="checkbox"/> A-Des <input type="checkbox"/> In-transit |                                 |  |

INMATE: PLEASE COMPLETE ITEMS 1-14. For non-English speaking, template provided in: ☐ Spanish ☐ Other \_\_\_\_\_

1. MEDICATIONS: Please list all current medications, doses, and date/time last taken:

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|  |
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|  |

2. ALLERGIES: Please check any allergies you have had.

|  |           |                                 |
|--|-----------|---------------------------------|
| <input type="checkbox"/> Medications:  | <u>NA</u> | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Foods (list): | <u>NA</u> | <input type="checkbox"/> Other: |

3. MEDICAL ILLNESSES: Please check any conditions you currently have or have had in the past.

|   |                                     |                                      |  |  |
|---|-------------------------------------|--------------------------------------|--|--|
| <input type="checkbox"/> Heart attack/disease | <input type="checkbox"/> Blood clot | <input type="checkbox"/> Angina      | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Lung disease         | <input type="checkbox"/> Asthma     | <input type="checkbox"/> Stroke      | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures/Epilepsy   |
| <input type="checkbox"/> Cancer Type: _____   | When: _____                         | <input type="checkbox"/> Other _____ |  |  |

4. INFECTIOUS DISEASE: Please check any conditions you currently have or have had in the past.

|  |   |
|--|---|
| <input type="checkbox"/> Positive or Negative TB skin test history.<br>Where treated? _____<br>When treated? _____ | <input type="checkbox"/> Ever been treated for Tuberculosis (TB)? <input type="checkbox"/> Have you had a cough for more than 2 weeks? <u>NO</u><br><input type="checkbox"/> Are you coughing up blood? <u>NO</u> Do you have night sweats or fevers? <u>NO</u><br><input type="checkbox"/> Have you recently lost weight? <u>NO</u> How many pounds? <u>NO</u> |
| <input type="checkbox"/> Chickenpox or shingles  | <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Do you currently have a rash, open sore or wound?<br>Where: _____  |
| <input type="checkbox"/> HIV (how long)<br>Month and year of diagnosis _____                                       | <input type="checkbox"/> Hepatitis (Type/s) _____ <input type="checkbox"/> Herpes <input type="checkbox"/> Lice<br><input type="checkbox"/> Blood transfusion <input type="checkbox"/> When: _____<br><input type="checkbox"/> Why: _____   |
| <input type="checkbox"/> Recent travel outside US:<br>When: _____<br>Where: _____                                  | <input type="checkbox"/> Syphilis <input type="checkbox"/> Treated?<br>When: _____<br>Where: _____  |

Are you at risk for HIV and/or hepatitis due to sharing needles, high-risk sex or tattooing? ☐ Yes ☒ No ☐ Don't know  
(If you do not know, please discuss any concerns with a health care provider and request testing if appropriate)

5. NERVOUS CONDITIONS/MENTAL HEALTH CONDITION: Please check any conditions you currently have or have had in the past.

|  |   |   |
|--|---|---|
| Have you ever had a mental illness? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify: _____ |   |   |
| <input type="checkbox"/> Suicidal thoughts<br>When: <u>NA</u>  | <input type="checkbox"/> Head injury<br>When: <u>NA</u><br>How: _____ | <input type="checkbox"/> Loss of Consciousness<br>When: <u>NA</u><br>How: _____ |
| <input type="checkbox"/> Suicide Attempt<br>When (month/year): _____   | How: _____  | Were you hospitalized? _____  |

6. DRUGS AND ALCOHOL: Are you now using, or have you in the past used any of the following:

| SUBSTANCE   | HOW USED (Needle, Smoked, Snorted, Pills) | DATE OF LAST USE |
|---|---|------------------|
| <input type="checkbox"/> Tranquilizers (Valium, Xanax, etc) | <u>NA</u>                                 |                  |

|   |  |  |
|---|--|--|
| <input type="checkbox"/> Opiates (Heroin, Methadone, Oxycontin, Vicodin, other) |  |  |
| <input type="checkbox"/> Barbiturates (phenobarbital, Seconal, other)           |  |  |
| <input type="checkbox"/> LSD/Hallucinogens/PCP                                  |  |  |
| <input type="checkbox"/> Marijuana  |  |  |
| <input type="checkbox"/> Other  |  |  |

**Alcohol History:** Please complete the following:

|                                      |                            |              |                    |
|--------------------------------------|----------------------------|--------------|--------------------|
| Type used: (beer, wine, vodka, etc.) | How often: (daily, weekly) | Usual Amount | Date of last drink |
|                                      |                            |              |                    |

Have you ever had, or are you now having, any withdrawal symptoms when you have stopped using drugs or alcohol: ☐ No ☐ Yes  
If yes, please describe: \_\_\_\_\_

**Do you use:**

|   |                          |                       |
|---|--------------------------|-----------------------|
| Tobacco: <input type="checkbox"/> Yes <input type="checkbox"/> No | How much? _____ Pack/Day | How long? _____ Years |
|---|--------------------------|-----------------------|

**7. PAIN ASSESSMENT:**

Do you currently suffer from any painful condition? ☐ No ☒ Yes - Pain Scale 0-2-4-6-8-10 (0 being no pain/10 being worst possible pain)  
Location: Back Onset: \_\_\_\_\_ Duration: \_\_\_\_\_ Description: \_\_\_\_\_  
How do you currently control the pain?(medication, rest) \_\_\_\_\_ Is this method effective? \_\_\_\_\_

**8. DENTAL:** Do you currently have any of the following:

|   |   |  |
|---|---|--|
| <input type="checkbox"/> Pain in teeth or mouth | <input type="checkbox"/> Swelling in mouth, jaws, or neck | <input type="checkbox"/> Dental emergency which you feel must be addressed immediately |
|---|---|--|

**9. HISTORY OF ABUSE:** Please complete the following if applicable:☐ Not applicable

|                                    |                     |
|------------------------------------|---------------------|
| TYPE OF ABUSE                      | WHAT AGE(s) OR WHEN |
| <input type="checkbox"/> Physical  |                     |
| <input type="checkbox"/> Emotional |                     |
| <input type="checkbox"/> Sexual    |                     |

**10. FEMALE HEALTH:** Women please complete the following:

|   |  |  |
|---|--|--|
| Date of last menstrual period: _____  | # of Pregnancies: _____  | Are you pregnant now?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know  |
| Date of last pap smear: _____   | Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't know                       | Have you ever had any of the following? (If yes, what year?)<br><br><input type="checkbox"/> Abnormal Pap _____<br><input type="checkbox"/> Breast Biopsy _____<br><input type="checkbox"/> Hysterectomy _____ |
| Date of last mammogram: _____   | Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't know                       |  |
| Type of Birth Control: <input type="checkbox"/> Birth Control Pills <input type="checkbox"/> IUD <input type="checkbox"/> Diaphragm <input type="checkbox"/> None <input type="checkbox"/> Other: _____ |  |  |
| Are you taking hormones for menopause or after hysterectomy?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | Check vaccinations you have had:<br><input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella |  |

**11. ALL INMATES - Please describe any other medical or mental health concerns you have:**

|  |
|--|
|  |
|  |
|  |
|  |

**12. DIET:**

|                                   |                                   |                                  |                                     |                                      |
|-----------------------------------|-----------------------------------|----------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Low salt | <input type="checkbox"/> Low fat | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Other _____ |
| Current weight: _____             | Usual weight: _____               |                                  |                                     |                                      |

**13. IMMUNIZATIONS:** Have you received any of the following vaccinations:

|  |                                      |                                      |  |
|--|--------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Tetanus (when): _____ | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Pneumonia ["Pneumovax"] (when): _____ |
|--|--------------------------------------|--------------------------------------|--|

I have answered all questions truthfully and to the best of my ability.

|                                      |                       |
|--------------------------------------|-----------------------|
| Inmate Signature: <u>Linda Kelly</u> | Date: <u>11-30-05</u> |
|--------------------------------------|-----------------------|

Last Name  
**KELLY**  
First Name  
**LESLIE**  
Middle Name  
**ROMILE**

Ht. 5' 9" Wt. 200  
Rt. BLK Ey. BRO

REG# 26864-039 TAL



20004-039 KELLY

delete the following:

Register No:

Institution:

FDC-TALLAHASSEE

PART  
2

| ISSUE OR CONDITION   | COMMENTS (Indicate if urgent treatment is necessary) |
|--|--|
| Infectious disease: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Draining skin lesions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Signs of lice? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Signs of scabies? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| <input type="checkbox"/> Skin condition: include trauma markings, bruises, jaundice, recent tattoos, needle marks, or other indications of drug use  |  |
| <input type="checkbox"/> Drug/alcohol withdrawal   |  |
| <input type="checkbox"/> Mental Health Issues  |  |
| <input type="checkbox"/> Pain Management   |  |
| <input type="checkbox"/> Physical disabilities/deformities   |  |
| <input type="checkbox"/> Cardiovascular disease  |  |
| <input type="checkbox"/> Diabetes  |  |
| <input type="checkbox"/> Asthma  |  |
| <input type="checkbox"/> Cancer  |  |
| <input type="checkbox"/> Dental problems   |  |
| <input checked="" type="checkbox"/> Other: <i>HIV / 2 Lipids / Migraines</i>   |  |

B. OTHER COMMENTS OR PHYSICAL FINDINGS: (Record vital signs if indicated)

|                       |
|-----------------------|
| NKDA                  |
| <i>See 71 For med</i> |
|                       |
|                       |
|                       |
|                       |
|                       |
|                       |

C. ☐ MEDICATION AND OTHER ORDERS WRITTEN ON SF-600 FORM

D. ☐ MEDICATION CONSENT FORMS SIGNED

E. ☒ INSTRUCTED INMATE HOW TO OBTAIN MEDICAL, DENTAL, AND MENTAL HEALTH SERVICES

|                     |  |
|---------------------|--|
| Provider Signature: | Printed Name/Credentials:<br><b>G. MARTEL R.P. FDC-TAL</b> |
| Date: 11/23/05      | Time: 1100   |